STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001129	A. BLDG: 00 B. WING:	04/20/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MID-ATLANTIC GASTROINTESTINAL CENTER STATE LICENSE NUMBER: **15891501**	**2112 HARRISBURG PIKE, SUITE 100** **LANCASTER, PA 17601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 0000	INITIAL COMMENT This report is the result of a State licensure survey conducted on April 20, 2023, at Mid-Atlantic Gastrointestinal Center. It was determined the facility was not in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Ambulatory Care Facilities, Annex A, Title 28, Part IV, Subparts A and F, Chapters 551-573, November 1999.	S 0000		
S 6721		S 6721		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001129	A. BLDG: 00 B. WING:	04/20/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MID-ATLANTIC GASTROINTESTINAL CENTER STATE LICENSE NUMBER: **15891501**	**2112 HARRISBURG PIKE, SUITE 100 LANCASTER, PA 17601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 6721	Continued from page 1 567.3 (b) (11) Policies and Procedures 567.3 Polcies and procedures (b) Current written policies and procedures to assure definite and valid infection control shall include,but not be limited to, the following: (11) Staff health status requirements This REGULATION is not met as evidenced by:	S 6721	Initial Comments S0000 Notification to Center The Center Administrator (CA) notified the Medical Director and Governing Board (GB) of the preliminary findings from the agency visit on 4/20/2023. 567.3 (b)(11) Policies and Procedures S6721 Systematic Changes & Sustaining the Plan The CA reviewed the policy named 'Tuberculosis Exposure Control Plan' , reviewing the process for implementation of the Tuberculosis Control Program for new employees. The policy update included a statement that 'all new hires will have TB testing done upon hire.' The CA will review all employee health files to verify that the process for TGB screening and Mantoux TST was followed according to policy. For the employee files found out of compliance with the policy, the CA will update files and treat each as a new employee. All new employees are to be screened for the presence	Completion Date: **05/15/2023** Status: **APPROVED** Date: **05/08/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001129	A. BLDG: __00_____ B. WING: _____	04/20/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MID-ATLANTIC GASTROINTESTINAL CENTER STATE LICENSE NUMBER: **15891501**	**2112 HARRISBURG PIKE, SUITE 100 LANCASTER, PA 17601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 6721	Continued from page 2	S 6721	of M. tuberculosis using the Mantoux TST and the completion of the Tuberculosis Symptom Evaluation –Negative For-upon hire. Skin Testing: employs the two-step procedure. (If the reaction to the first test is less than 10 mm, a second test is given 1 - 3 weeks later). If the second test remains negative, the person is classified as uninfected. Employees with a positive second test should be evaluated to rule out infection with M tuberculosis. TST within 12 Months: If the employee can provide documentation of a negative TST done in the past 12 months, they will complete the Tuberculosis Symptom Evaluation-Negative form and only a one-step test is done. Positive TST: Individuals with positive TST, >10 mm are referred for follow-up and/or treatment and may return with a letter attesting to the non- infectious nature of the applicant prior to initiation of work. Individuals with a documented history of a positive TST do not undergo skin testing but must	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001129	A. BLDG: 00 B. WING:	04/20/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MID-ATLANTIC GASTROINTESTINAL CENTER STATE LICENSE NUMBER: **15891501**	**2112 HARRISBURG PIKE, SUITE 100 LANCASTER, PA 17601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 6721	Continued from page 3	S 6721	provide evidence of their TB evaluation, chest X- ray. Monitoring Our target for compliance with the Tuberculosis Exposure Control Plan is 100%. To ensure sustained compliance, the Director of Operations (DOO) will review the health files of the next 2 new employees, confirming the policy and documentation was followed as per the policy. Any area of non-compliance will be managed by the DOO as an opportunity for re-education. Responsible Party The Administrator is responsible to implement the changes identified in this POC. Documentation of compliance with this PoC will be discussed with the Quality Assessment and Performance Improvement (QAPI) Committee. Minutes from the QAPI Committee and Medical Executive Committee (MEC), and will serve as a validation that the groups were informed, and the systemic changes	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001129	A. BLDG: __00_____ B. WING: _____	04/20/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MID-ATLANTIC GASTROINTESTINAL CENTER STATE LICENSE NUMBER: **15891501**	**2112 HARRISBURG PIKE, SUITE 100 LANCASTER, PA 17601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 6721	Continued from page 4	S 6721	addressed here recommended to the GB for approval at the next scheduled meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001129	A. BLDG: 00 B. WING:	04/20/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MID-ATLANTIC GASTROINTESTINAL CENTER STATE LICENSE NUMBER: **15891501**	**2112 HARRISBURG PIKE, SUITE 100 LANCASTER, PA 17601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 6721	Continued from page 5 Based on review of facility documents, personnel files (PF), and staff interview (EMP), it was determined the facility failed to follow facility policy to ensure tuberculosis screening was completed on one of ten personnel files reviewed (PF3). Findings include: On April 20, 2023, review of facility's policy "Tuberculosis Exposure Control Plan" last revised May 2019, revealed "Purpose: To minimize exposure to, and subsequent infection with, tuberculosis (TB) ... C. Prospective Employees 1. All new employees are screened for presence of infection with M. tuberculosis using the Mantoux TST and the completion of the Tuberculosis Symptom Evaluation - Negative form ... 4. Employees will complete the Tuberculosis Symptom Evaluation upon hire and if symptom free will be administered Mantoux TST and allowed to work (enter state specific requirements as necessary). The second step will be administered 1 -3 weeks later.	S 6721		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001129	A. BLDG: 00 B. WING:	04/20/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MID-ATLANTIC GASTROINTESTINAL CENTER STATE LICENSE NUMBER: **15891501**	**2112 HARRISBURG PIKE, SUITE 100 LANCASTER, PA 17601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 6721	Continued from page 6 On April 20, 2023, review of PF3 revealed employee was hired August 2022. PF3 file did not contain a Tuberculosis Symptom Evaluation form, also did not contain documentation of completed two step Mantoux Tuberculin Skin Testing. Interview with EMP1 on April 20, 2023, EMP1 confirmed PF3 did not contain a Tuberculosis Symptom Evaluation form or documentation of a completed two step Mantoux Tuberculin Skin Testing.	S 6721		

Certified End Page

MID-ATLANTIC GASTROINTESTINAL CENTER

STATE LICENSE NUMBER: 15891501

SURVEY EXIT DATE: 04/20/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY